Vanderbilt University Medical Center

AFFIDAVIT OF MEDICAL RECORDS CUSTODIAN

I, the undersigned, declare as follows:

1. I am the duly authorized custodian of the records in the Medical Information Services Department at Vanderbilt University Medical center ("VUMC") and I have the authority to certify the authenticity of records prepared by VUMC personnel.

2. Based upon a diligent search of the records currently maintained or provided to the VUMC Medical Information Services department, I am producing herewith in a sealed envelope authentic copies of the records that have been requested, which have been located in this department regarding the referenced patient as of the date this affidavit is executed. These records may not include the following:
   a) Any records that may be subject to the specific disclosure requirements pursuant to 42 U.S.C. §290dd-2 et seq., and/or Tennessee Code Annotated §33-3-104(10),
   b) Any records that may be maintained by individual clinics (including off-site clinics) and which are not maintained in the central hospital record, unless otherwise specified herein,
   c) Non-clinical correspondence from outside parties,
   d) Any records originating from other outside facilities,
   e) Any records that have not yet been transmitted to this office for filing in the patient's chart, or records that have not yet been scanned into the electronic medical record.

3. These records and related records from other departments, such as billing and radiology records (other than records from outside facilities) have been prepared by VUMC personnel pursuant to Tennessee Code Annotated § 68-11-301 and have been maintained in or provided to the Medical Information Services department in the ordinary course of business and:
   a) They were made at or near the time of the occurrence of the matters set forth by, or from information transmitted by, a person with the knowledge of these matters;
   b) They were kept in the course of the regularly conducted activity; and
   c) They were made by the regularly conducted activity as a regular practice.

4. I declare that the above statements are true and correct to the best of my knowledge, information, and belief based upon diligent inquiry.

Executed on this 12th day of Oct., 2011.

Pamela J. Cheney 6/14/1952 Freda Scott

Freda Scott, RHIA

STATE OF TENNESSEE
COUNTY OF DAVIDSON

Sworn to before me this 12th day of Oct., 2011.

Glenda Fendley
NOTARY PUBLIC

GLENDA FENDLEY
STATE OF TENNESSEE NOTARY PUBLIC
DAVIDSON COUNTY
My Commission Expires 2014

EXHIBIT 13

0329478889 CHERRY, PAMELA J (06/14/1952 - then 58YO F)

FORM Report of Death 2011/06/01 02:06 Created by: Peggs, Kiffany J Electronically signed by: Peggs, Kiffany J (physician) on 2011/06/01 03:27

Amended by peggszn (Peggs, Kiffany J) on 2011/06/01 03:27:52 as follows:

patient family declined autopsy, date of death 6/1/2011

Amended by peggszn (Peggs, Kiffany J) on 2011/06/01 03:24:12 as follows:

date of death 6/1 patietn family declined autopsy

Vanderbilt University Medical Center

REPORT of DEATH

A. Demographics

1. Date of Arrival: 05/31/2011
2. Date of Death: 06/02/2011
3. Official Time of Death: 0153
4. DOA? ☐ Yes ☒ No
5. Did Patient Have Communicable Disease? ☐ Yes ☒ No ☐ Unknown
6. Admit Diagnosis: STEMI winth VF arrest
7. Immediate Cause of Death: cardiogenic shock secondary to above
8. Secondary To:
9. Family Member Notified of Death:

☒ Yes ☐ No

Name/Relationship of person notified: David Cherry/husband

Part B - Death Certificate:

Name of Attending Responsible to sign State Death Certificate- Tennessee Law states The Death Certificate will be signed by "The physician in charge of the patient's care for the illness or condition that resulted in death within 48 hours after the death." The Medical Examiner will assume the responsibility for signing the Death Certificate when the case has been accepted by their office.

1. Please specify the physician to sign the Death Certificate: Joe Freddi, MD
2. Phone number for responsible physician: 322-2318

032947889 CHERRY, PAMELA J (06/14/1952 - then 59YO F)

Part C - Reporting Requirements
Medical Examiner Notification:

4. Has a reportable event occured?

☐ Yes ☒ No

a. Was Medical Examiner notified for consultation?
☒ Yes ☐ No
b. Name of Medical Examiner Notified: Lancor Vance
c. Date of Notification: 06/01/2011 Time of Notification: 0200
d. Notified by: Kiffany Peggs MD
e. Case Accepted?
☐ Yes ☒ No

5. TDS Notification: All deaths are to be reported to TDS.

Was TDS notified? ☒ Yes ☐ No

D. VUMC Autopsy:

Autopsy requested by physician? ☐ Yes ☒ No
If autopsy is to be completed, has a signed consent been obtained? ☐ Yes ☒ No
Autopsy requested by family? ☐ Yes ☒ No
If autopsy is to be completed, has a signed consent been obtained? ☐ Yes ☒ No
Autopsy declined by family Yes ☒ No

Electronic Signature:

☒ Peggs, Kiffany J

DECEDENT AFFAIRS

A. TDS

1. Organ Donor: ☐ Accepted ☒ Declined ☐ Other - See Decedent Affairs Log
2. Tissue Donor: ☒ Accepted ☐ Declined ☐ Other - See Decedent Affairs Log

B. TDS Notification: All deaths are to be reported to TDS.

a. TDS Notified (date): 06/01/2011
b. Name of TDS staff notified: Rick Wyman
c. Case Accepted: ☒ Accepted ☐ Declined ☐ Pending

C. Body Removed by:

☒ Funeral Home ☐ Transport Services ☐ Family/Representative ☐ Medical Examiner
Name: Carlisle & Son Funeral Chapel

0329478889 CHERRY, PAMELA J (06/14/1952 - then 58YO F)

Address: 39 East High Street Mooresville Indiana 46158
Electronic Signature:
☒ Williams, Marie

032947889 CHERRY, PAMELA J (06/14/1952 - then 58Y0 F)

Death Summary 2011/06/01 01:40 Created by: Peggs, Kiffany J Electronically signed by: Peggs, Kiffany J (physician) (peggsm) on 2011/06/01 02:03:46

VANDERBILT UNIVERSITY MEDICAL CENTER
DEATH SUMMARY
VANDERBILT UNIVERSITY HOSPITAL

Date of services: Wednesday, 06/01/2011 01:40
ATTENDING PHYSICIAN: Fredi, Joseph L.

PATIENT NAME: Cherry, Pamela J MR# 032947889
DATE ADMITTED: 05/31/2011
DATE OF DEATH: 06/01/2011 TIME OF DEATH: 0153
DEPARTMENT: CCU

ADMITTING DIAGNOSIS: STEMI with out of hospital VF arrest

FINAL PRINCIPAL DIAGNOSIS: 1. Cardiogenic shock

CAUSE OF DEATH: 1. STEMI with out of hospital VF arrest

SECONDARY DIAGNOSIS: 1. Metabolic acidosis
2. Respiratory failure
3. Diabetes Mellitus type 2

EVENT OR COMPLICATION(S) PRECEDING DEATH:
-Cardiac arrest

EXPECTED DEATH: yes, classified as:
select from side of screen

Disposition of Case Review: DNR; Date/Time of DNR: 6/1/2011 0131
-Irreversible condition

PROCEDURES:
Cardiac Catheterization and Intervention Report

Coronary Arteriography :

LM: normal. LAD: mild luminal irregularities. LCX: mild luminal irregularities. RCA: dominant vessel; acute proximal occlusion with thrombus.

Intervention :

Aspiration thrombectomy and intervention to RCA with overlapping 2.5 x 28mm and 2.5 x 18mm Promus drug-eluting stents. Placement of intra-aortic balloon pump.

HOSPITAL COURSE:
Patient was admitted and iniated on hypothermia protocol. Initally she did however after 3 to 4 hours began to have increasing pressor requirements. The patient initally responded to fluids however even with optimal pressor support and mechanical support the patient was not able to maintain her hemodynamics. The family was called othe bedside and they made the decision that she would not wanto continue on this way especially given how grim her prognosis was. The family made her DNR and want to stop support. The patient expired within minutes.

PROBLEM LIST: as above.

032947889 CHERRY, PAMELA J (06/14/1952 - then 59YO F)

Written by:
Peggs, Kiffany J, M.D.
Vanderbilt University Medical Center Release of Information (615) 322-2052

032947889 CHERRY, PAMELA J (06/14/1952 - 59YO F)

FORM Transfer Note (Cardiology) 2011/05/31 09:06 (Last modified by Ludwig, Judy L) Electronically signed by: Ludwig, Judy L on 2011/05/31 09:06

[redacted]

Vanderbilt Heart

Date of services: 05/31/2011
AccessCoordinator:Judy Ludwig
Last Name: Cherry First Name: Pamela
Caller: Chun VUH Representative: Fredi, Joseph L.
Referring MD: Chunn, Stanley Contact Number: 615-666-2147-384

What specialty service, hospital or ER is (s)he calling from? Macon Co. General
Present location of patient: [X] ED [ ] Outpatient [ ] Inpatient [ ] Other
Emergency Medical Condition Present: [X] Yes [ ] No

Admitting MD: Fredi, Joseph L. Teaching Service: [X] Yes [ ] No

Admission Status: [X] ICU [ ] SDU [ ] ER [ ] OR [ ] CCL [ ] OBS [ ] Other

Reason for Transfer: [ ] Emergent medical condition [ ] STEMI network [ ] Specialist needed [X] Higher level of care
[ ] Family/Pt. request [ ] Prior VUH pt. [ ] VUH solo provider [ ] Other

Method of Transport: [X] Air [ ] Ambulance [ ] Private car [ ] Other

Intubated?: [X] yes [ ] no Hypothermia Protocol?: [X] yes [ ] no
Temp Height Weight B/P 80/50 HR RR SaO2
Drips dopamine 20 mcg

Does patient have any of the following?
- Immediate Risk for Coronary Syndrome
- STEMI
- NSTEMI
- Unstable Angina
- Acute Chest Pain
- EKG changes
- elevated Troponin levels
- elevated Cardiac Enzymes
If so, please check here: [X] ACS

Clinical Status/ Information: Pt went to local ER last pm with cp, neg workup, sent home. Collapsed at home CPR started immediately. EMS arrived intubated and 2 amps of Epi came in with V Fib in progress. Converted to NSR with ST elevation in Inferior leads. Dr. Fredi advised to pack in ice and give cool saline. Dopamine drip at 20 mcg/kg with B/P of 80/50. Non responsive, pupils dilated. Life flight on way to get pt.

Clinician Notified: Goyal

Prior Authorization or Precertification required: ☐ Yes ☒ No

032947889 CHERRY, PAMELA J (06/14/1952 - then 58YO F)

FORM History and Physical (Internal Medicine) 2011/05/31 01:40 Created by: Peggs, Kiffany J
Electronically signed by: Peggs, Kiffany J (physician) on 2011/06/01 01:40

Vanderbilt University Medical Center

INTERNAL MEDICINE HISTORY AND PHYSICAL

Name: CHERRY, PAMELA J
MRN: 032947889
Date of Service: 05/31/2011
Time of Service:

History of Present Illness:

Mrs. Cherry is a 58 year old female who presented to an OSH after a witnessed VF/PEA arrest at home. One day prior to this the patient had been complaining of chest pressure and went to an OSH ER where she was seen and sent home. Several hours later she had a VF arrest at home. CPR was started by her husband and EMS was called. Rythm was VF/PEA there wasa 40 minute CPR from the scene tothe OSH. Patient arrested again on lifeflight with PEA and then finally had VF in the cath lab. The patient had PCI for a 100% occluded RCA and started on cooling protocol. Down time was 6AM. The patient was started on amiodarone for repeated VF.

Medical History:

Crohn's disease

Depressive disorder

Surgical History:

No significant history noted.

Medications:

Zoloft
reported steriod use

Allergies:

No known drug allergies

0329478889 CHERRY, PAMELA J (06/14/1952 - then 58YO F)

Family Medical History:
Mother CVA
Father h//o colon cancer

Social History:
Married
Smoking history 1ppd

Review of Systems:
Review of 10+ systems is negative except as discussed under History of Present Illness.

Physical Exam:
Vital Signs:
Temp: 89.1 deg F
Pulse: 100
Resp: 14
BP: 119/80
O2Sat: .
Weight (lbs): 154 lb 5 ounce

Exam:
GENERAL: Awake, alert, in no acute distress.
HEENT: Normocephalic, atraumatic. Conjunctiva clear. Mucous membranes moist. Pupils equal, reactive. Extra-ocular movements normal.
NECK: Full range of motion.
RESPIRATORY: Good air movement.
CARDIOVASCULAR: Regular rate and rhythm.
ABDOMEN: Abdomen nondistended.
NEUROLOGIC: Cranial nerves II-XII normal. Motor strength 5/5 in extremities. mental status normal.
EXTREMITIES: No pedal edema. No deformity.

Pertinent Laboratory Findings:
pH: 7.08 (05/31/11)
pCO2: 43 (05/31/11)
pO2: 215 (05/31/11)
HCO3Ca: 12.7 (05/31/11)
O2SatC: 100.0 (05/31/11)
BEAR: -16.6 (05/31/11)
Na-WB: 134 (05/31/11)
K-WB: 5.2 (05/31/11)
GluWB: 371 (05/31/11)
HCTWB: 37 (05/31/11)
LAC: 8.8 (05/31/11)

HgbA1C: 6.1 (05/31/11)
CPK: 1042 (05/31/11)
CKMBRe: 397.97 (05/31/11)
MBRat: 38.2 (05/31/11)
TRPI: 396.70 (05/31/11)
Mg: 3.1 (05/31/11)
Na: 146 (05/31/11)
K: 3.0 (05/31/11)
Cl: 108 (05/31/11)
CO2: 25 (05/31/11)
BUN: 17 (05/31/11)
Creat: 1.33 (05/31/11)
eGFR: 41 (05/31/11)
eGFRAA: 49 (05/31/11)
Gluc: 230 (05/31/11)
Ca: 8.8 (05/31/11)
AN-GAP: 13 (05/31/11)
WBC: 22.5 (05/31/11)
Hgb: 12.3 (05/31/11)
PCV: 37 (05/31/11)
Plt-Ct: 233 (05/31/11)
RBC: 3.81 (05/31/11)
MCV: 97 (05/31/11)
MCH: 32.3 (05/31/11)
MCHC: 33.4 (05/31/11)
RDWSD: 48.1 (05/31/11)
RDW: 13.8 (05/31/11)

Impressions from Select Radiology Reports:

All radiology data for this patient has been reviewed, please see plan for any comments, corrections, of changes based on this data.

Assessment and Plan:

SYNOPSIS: 58 year old female with a PMH of HTN presnted to OSH after a witness VF/PEA arrest at home. Now s/p PCI with a BMS to a 100% occluded RCA.

PROBLEMS:
Acute ST segment elevation myocardial infarction: :
- patient status post stenting to the RCA
- started on cooling protocol down time at 6AM
- ASA, Plavix
- Intensive care team consulted

Electronically Signed By:

Peggs, Kiffany J (peggszm)

CASE SYNOPSIS

Name: CHERRY, PAMELA	Date: 05-31-2011
MRN: 32947889	Proc: Adult: Interventional

Medication(s)

09:23:20	Amiodarone 150MG IV ^05-31 {by Ruzic, Danielle RN}
09:32:35	Sodium Bicarbonate 2 mEq IV ^05-31
09:36:32	Calcium Chloride 1amp IV ^05-31
09:37:18	Vasopressen 40 mg IV ^05-31
09:40:41	Insulin 10 ^05-31
09:40:54	Sodium Bicarbonate 2 mEq IA ^05-31
09:50:12	Insulin 10 ^05-31
10:02:53	Heparin 7,000 units ^05-31
10:04:53	Nitro 200 mcg IC ^05-31
10:26:35	Heparin 3,000 units IV ^05-31

Pre Procedure Notes

09:16:50	Emergent procedure ^05-31
09:16:56	PT ARRIVED FROM LifeFlight Helicopter & placed on procedure table. ^05-31
09:17:04	PATIENT IDENTIFICATION by two identifiers: Patient Name and Date of Birth ^05-31
09:17:05	Patient Identification Source: Patient ^05-31
09:17:07	ID BAND ON: Accuracy of information verified, proceeding with planned ^05-31
09:17:08	procedure with IV site patent and free of infiltration or inflammation. ^05-31
09:17:10	HAS PT RECEIVED CONTRAST MEDIA IN LAST 24 Hrs: NO ^05-31
09:17:12	6-LEAD ECG RECORDED NIBP, SPO2 monitoring activated. ^05-31
09:20:01	POSITIONING & COMFORT Aids used: Arms at patients sides Fingertips within ^05-31
09:20:02	armboards. ^05-31
09:20:56	POSITIONING & COMFORT Aids used: Safety Straps ^05-31
09:21:12	Adult Interventional Fellow Already in Procedure Suite. ^05-31
09:21:14	Adult Interventional Attending Already in Procedure Suite. ^05-31
09:21:20	Prior to administration of sedation ASA class: II ^05-31
09:21:29	PT PREPPED w/Chloroprep & Draped - Bilat groin ^05-31
09:25:17	Verified Patient Selection in Imaging System and Hemodynamic System ^05-31
09:25:17	STAFF #1 Confirming Pre Procedure Brief Completed and consent verified: ^05-31
09:25:18	STAFF #2 Confirming Pre Procedure Brief Completed and consent verified: ^05-31
09:25:19	STAFF #3 Confirming Pre Procedure Brief Completed and consent verified: ^05-31
09:25:23	Intervention PROCEDURE STARTED. ^05-31
09:26:09	ABOVE DOCUMENTED BY: ^05-31
09:27:29	Local anesthesia to right groin area ^05-31
09:28:28	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in ^05-31
09:28:36	ACCESS: Sheath into right femoral vein ^05-31
09:30:41	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in ^05-31
09:30:50	ACCESS: Sheath into right femoral artery ^05-31
09:31:02	ABOVE DOCUMENTED BY: ^05-31
09:35:25	Pt intubated ^05-31
09:35:33	See anesthesia record for Sedation documentation. ^05-31
09:35:40	See anesthesia record for Induction/intubation. ^05-31
09:41:59	Local anesthesia to left groin area ^05-31
09:52:11	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in ^05-31

09:52:17 ACCESS: Sheath into left femoral artery ^05-31
10:07:37 VASCULAR access obtained with Standard Needle: 18ga x 2.75 in ^05-31
10:07:54 ACCESS: Sheath into left femoral vein ^05-31

INTV Intra Proc Notes

09:27:04 DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful ^05-31
09:29:05 EQUIPMENT: Temporary Pacer: Arrow Bipolar Electrode 5 fr, 110cm ^05-31
09:33:00 CPR ^05-31
09:33:13 ABOVE DOCUMENTED BY: ^05-31
09:33:39 CPR INITIATED No pulse ^05-31
09:34:31 TEMP PACER inserted ^05-31
09:38:14 CPR PAUSED to check pt status No pulse ^05-31
09:38:20 CPR CONTINUED ^05-31
09:41:38 EQUIPMENT: IABP: Arrow 40ml ^05-31
09:45:02 CPR PAUSED to check pt status V Tach / V Fib ^05-31
09:45:38 DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful ^05-31
09:45:51 IABP ECG leads connected to patient ^05-31
09:46:38 IABP set-up complete ^05-31
09:46:48 IABP inserted through sheath into Rt Femoral Artery ^05-31
09:49:24 IABP Settings: 1:1 ratio with ECG trigger ^05-31
09:51:41 EQUIPMENT: Catheter: Scimed 6F JL 4 ^05-31
09:53:47 Catheter in over wire; then wire out. ^05-31
09:54:52 ANGIOGRAM performed of LCA ^05-31
09:55:51 EQUIPMENT: Guide Catheter: Medtronic 6f Launcher JR 4.0 ^05-31
09:56:32 Guide Catheter in over wire; then wire out ^05-31
09:56:44 EQUIPMENT: Guidewire: Medtronic Cougar XT .014 190cm ^05-31
09:56:53 Guidewire inserted ^05-31
09:57:02 {COR VESSEL} RCA ^05-31 {L1}
09:58:17 DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful ^05-31 {L1}
09:58:34 Guidewire inserted ^05-31 {L1}
09:59:00 EQUIPMENT: Balloon: Scimed Apex Monorail 2.0 x 15mm ^05-31 {L1}
09:59:23 EQUIPMENT: Aspiration catheter:6 fr. Export ^05-31 {L1}
09:59:59 Guidewire successfully crossed lesion ^05-31 {L1}
10:00:14 Aspiration catheter inserted over wire into vessel - ^05-31 {L1}
10:00:57 Aspiration catheter out unable to pass ^05-31 {L1}
10:01:31 Balloon inserted over guidewire ^05-31 {L1}
10:01:33 Balloon successfully crossed lesion ^05-31 {L1}
10:03:54 PTCA Balloon Inflated @ 12 Atms for 10 secs ^05-31 {L1}
10:04:27 PTCA Balloon Re-Inflated @ 10 Atms for 10 secs ^05-31 {L1}
10:05:13 PTCA Balloon Re-Inflated @ 12 Atms for 10. secs ^05-31 {L1}
10:09:15 ACT ordered,drawn & tested (Interventional Target Range200-300)via Hemochron ^05-31 {L1}
10:09:16 Jr. - # S-3896 ^05-31 {L1}
10:15:08 EQUIPMENT: Drug-Eluting Stent: B/S Promus RX 2.5 x 28mm ^05-31 {L1}
10:15:14 Drug-Eluting Stent in over guidewire ^05-31 {L1}
10:15:21 Drug-Eluting Stent successfully crossed lesion ^05-31 {L1}
10:15:22 Stent Deployed @ 14 Atms for 15 secs ^05-31 {L1}
10:15:44 Stent Balloon out ^05-31 {L1}
10:16:03 EQUIPMENT: Drug-Eluting Stent: B/S Promus RX 2.5 x 18mm ^05-31 {L1}
10:17:38 Drug-Eluting Stent in over guidewire ^05-31 {L1}

10:17:56	Stent Deployed @ 14 Atms for 15 secs ^05-31 {L1}
10:18:21	Stent Balloon out ^05-31 {L1}
10:20:11	EQUIPMENT: Swan-Ganz Catheter: Edwards 7 fr TD ^05-31 {L1}
10:22:54	Temporary Pacer removed ^05-31 {L1}
10:23:05	EQUIPMENT: Sheath: Arrow 8.5 fr, 10 cm ^05-31 {L1}
10:23:22	Existing sheath exchanged for new sheath of different size per Procedure MD ^05-31 {L1}
10:26:25	ACT Results: 205 secs ^05-31 {L1}
10:27:31	Patient tolerated procedure well. ^05-31 {L1}
10:27:34	Intervention Procedure Complete. ^05-31 {L1}
10:27:37	INTV Contrast Type: Visipaque 320 ^05-31 {L1}
10:27:41	INTV Contrast Total: 125 ml ^05-31 {L1}
10:27:43	ABOVE DOCUMENTED BY: ^05-31 {L1}
10:34:48	Swan-Ganz Catheter: sutured in place @: 71 cms ^05-31 {L1}

Post Procedure Notes

10:27:56	Total Fluoro Time: 7.8 mins ^05-31
10:28:19	Total Images on X-Ray: 15 ^05-31
10:28:22	Total Icons on Heart Labs: 14 ^05-31
10:28:23	STAFF #1 Confirming Post Procedure Brief Completed ^05-31
10:28:24	STAFF #2 Confirming Post Procedure Brief Completed ^05-31
10:28:24	STAFF #3 Confirming Post Procedure Brief Completed ^05-31
10:28:34	FINAL VSS; NIBP: 187/138 mmHg; Heart Rate: 109 bpm; O2 Sat: 98% ^05-31
10:29:05	Arterial Sheath: Intact, sutured and capped; ^05-31
10:29:09	Arterial Sheath: Intact, sutured and capped; ^05-31
10:29:13	Venous Sheath: intact, sutured and capped; ^05-31
10:29:16	Venous Sheath: intact, sutured and capped; ^05-31
10:29:25	Site Status: No Bleeding/Hematoma - Rt groin. ^05-31
10:29:31	INTV Complications: NONE - During Lab Visit ^05-31
10:29:37	Patient transferred from Lab to Room 5007 ^05-31
10:29:40	ABOVE DOCUMENTED BY: ^05-31

PROCEDURE LOG

Name: CHERRY, PAMELA	Date: 05-31-2011
MRN: 32947889	Proc: Adult: Interventional

09:16:50	Emergent procedure
09:16:56	PT ARRIVED FROM LifeFlight Helicopter & placed on procedure table.
09:16:56	Patient In Room
09:17:04	PATIENT IDENTIFICATION by two identifiers: Patient Name and Date of Birth
09:17:05	Patient Identification Source: Patient
09:17:07	ID BAND ON: Accuracy of infomation verified, proceeding with planned
09:17:08	procedure with IV site patent and free of infiltration or inflammation.
09:17:10	HAS PT RECEIVED CONTRAST MEDIA IN LAST 24 Hrs: NO
09:17:12	6-LEAD ECG RECORDED NIBP, SPO2 monitoring activated.
09:20:01	POSITIONING & COMFORT Aids used: Arms at patients sides Fingertips within
09:20:02	armboards.
09:20:02	@HR 72 PRE LOC: 1 LOP: 0 RSP: 162 SPO2: NO PROBE
09:20:56	POSITIONING & COMFORT Aids used: Safety Straps
09:21:12	Adult Interventional Fellow Already in Procedure Suite.
09:21:14	Adult Interventional Attending Already in Procedure Suite.
09:21:20	Prior to administration of sedation ASA class: II
09:21:29	PT PREPPED w/Chloroprep & Draped - Bilat groin
09:21:29	Setup Completed
09:23:20	**Amiodarone 150MG IV (by Ruzic, Danielle RN)**
09:25:17	STAFF #1 Confirming Pre Procedure Brief Completed and consent verified:
09:25:17	Verified Patient Selection in Imaging System and Hemodynamic System
09:25:18	STAFF #2 Confirming Pre Procedure Brief Completed and consent verified:
09:25:19	STAFF #3 Confirming Pre Procedure Brief Completed and consent verified:
09:25:23	Begin Procedure
09:25:23	Intervention PROCEDURE STARTED.
09:26:09	ABOVE DOCUMENTED BY:
09:27:04	DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful
09:27:29	Local anesthesia to right groin area
09:28:28	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in
09:28:36	ACCESS: Sheath into right femoral vein
09:29:05	EQUIPMENT: Temporary Pacer: Arrow Bipolar Electrode 5 fr, 110cm
09:30:41	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in
09:30:50	ACCESS: Sheath into right femoral artery
09:31:02	ABOVE DOCUMENTED BY:
09:31:50	AO 64/21 (36) (ROOM AIR REST)
09:32:35	**Sodium Bicarbonate 2 mEq IV**
09:33:00	CPR
09:33:13	ABOVE DOCUMENTED BY:
09:33:39	CPR INITIATED No pulse
09:34:31	TEMP PACER inserted
09:35:00	@HR 28 DURING LOP: 1 RSP: 82 SPO2: 99 (Sinus Rhythm)
09:35:25	Pt intubated
09:35:33	See anesthesia record for Sedation documentation.
09:35:40	See anesthesia record for Induction/intubation.
09:36:32	**Calcium Chloride 1amp IV**
09:37:18	**Vasopressin 40 mg IV**
09:38:14	CPR PAUSED to check pt status No pulse
09:38:20	CPR CONTINUED
09:40:41	**Insulin 10**
09:40:54	**Sodium Bicarbonate 2 mEq IA**

09:41:38	EQUIPMENT: IABP: Arrow 40ml
09:41:59	Local anesthesia to left groin area
09:45:02	CPR PAUSED to check pt status V Tach / V Fib
09:45:38	DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful
09:45:51	IABP ECG leads connected to patient
09:46:38	IABP set-up complete
09:46:48	IABP inserted through sheath into Rt Femoral Artery
09:49:24	IABP Settings: 1:1 ratio with ECG trigger
09:50:01	@HR 108 DURING LOC: 1 LOP: 0 RSP: 13 SPO2: NO DATA (Sinus Rhythm)
09:50:12	Insulin 10
09:51:41	EQUIPMENT: Catheter: Scimed 6F JL 4
09:52:11	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in
09:52:17	ACCESS: Sheath into left femoral artery
09:53:47	Catheter in over wire; then wire out.
09:54:30	AO 198/ 71 (112) (ROOM AIR REST)
09:54:52	ANGIOGRAM performed of LCA
09:55:51	EQUIPMENT: Guide Catheter: Medtronic 6f Launcher JR 4.0
09:56:32	Guide Catheter in over wire; then wire out
09:56:44	EQUIPMENT: Guidewire: Medtronic Cougar XT- .014 190cm
09:56:53	Guidewire inserted
09:57:02	(COR VESSEL) RCA (L1)
09:58:17	DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful (L1)
09:58:34	Guidewire inserted (L1)
09:59:00	EQUIPMENT: Balloon: Scimed Apex Monorail 2.0 x 15mm (L1)
09:59:23	EQUIPMENT: Aspiration catheter:6 fr. Export (L1)
09:59:59	Guidewire successfully crossed lesion (L1)
10:00:14	Aspiration catheter inserted over wire into vessel - (L1)
10:00:57	Aspiration catheter out unable to pass(L1)
10:01:31	Balloon inserted over guidewire (L1)
10:01:33	Balloon successfully crossed lesion (L1)
10:02:53	Heparin 7,000 units
10:03:54	PTCA Balloon Inflated @ 12 Atms for 10 secs (L1)
10:04:27	PTCA Balloon Re-Inflated @ 10 Atms for 10 secs (L1)
10:04:53	Nitro 200 mcg IC
10:05:01	@HR 64 DURING LOC: 1 LOP: 0 RSP: 9 SPO2: NO DATA (Sinus Rhythm)
10:05:13	PTCA Balloon Re-Inflated @ 12 Atms for 10. secs (L1)
10:07:37	VASCULAR access obtained with Standard Needle: 18ga x 2.75 in
10:07:54	ACCESS: Sheath into left femoral vein
10:09:15	ACT ordered,drawn & tested (Interventional Target Range200-300)via Hemochron (L1)
10:09:16	Jr. - # 3-3896 (L1)
10:10:13	AO 105/ 48 (66) (ROOM AIR REST)
10:11:56	AO 124/ 53 (77) (ROOM AIR REST)
10:15:08	EQUIPMENT: Drug-Eluting Stent: B/S Promus RX 2.5 x 28mm (L1)
10:15:14	Drug-Eluting Stent in over guidewire (L1)
10:15:21	Drug-Eluting Stent successfully crossed lesion (L1)
10:15:22	Stent Deployed @ 14 Atms for 15 secs (L1)
10:15:44	Stent Balloon out (L1)
10:16:03	EQUIPMENT: Drug-Eluting Stent: B/S Promus RX 2.5 x 18mm (L1)
10:17:23	AO 128/ 54 (84) (ROOM AIR REST)
10:17:38	Drug-Eluting Stent in over guidewire (L1)
10:17:56	Stent Deployed @ 14 Atms for 15 secs (L1)

10:18:21	Stent Balloon out (L1)							
10:18:31	AO	137/57	(84)					(ROOM AIR REST)
10:20:00	@HR 98	DURING	LOC: 1	LOP: 0	RSP: 11	SPO2: NO DATA	(Sinus Rhythm)	
10:20:11	EQUIPMENT: Swan-Ganz Catheter: Edwards 7 fr TD (L1)							
10:22:54	Temporary Pacer removed (L1)							
10:23:05	EQUIPMENT: Sheath: Arrow 8.5 fr, 10 cm (L1)							
10:23:22	Existing sheath exchanged for new sheath of different size per Procedure MD (L1)							
10:26:25	ACT Results: 205 secs (L1)							
10:26:35	Heparin 3,000 units IV							
10:26:42	@HR 110	DURING	BP: 187/138	RSP: 11	SPO2: NO DATA	(Manual)		
10:27:31	Patient tolerated procedure well. (L1)							
10:27:34	Intervention Procedure Complete. (L1)							
10:27:34	Procedure End							
10:27:37	INTV Contrast Type: Visipaque 320 (L1)							
10:27:41	INTV Contrast Total: 125 ml (L1)							
10:27:43	ABOVE DOCUMENTED BY: (L1)							
10:27:56	Total Fluoro Time: 7.8 mins							
10:28:19	Total Images on X-Ray: 15							
10:28:22	Total Icons on Heart Labs: 14							
10:28:23	STAFF #1 Confirming Post Procedure Brief Completed							
10:28:24	STAFF #2 Confirming Post Procedure Brief Completed							
10:28:24	STAFF #3 Confirming Post Procedure Brief Completed							
10:28:34	FINAL VSS: NIBP: 187/138 mmHg; Heart Rate: 109 bpm; O2 Sat: 98%							
10:29:05	Arterial Sheath: Intact, sutured and capped;							
10:29:09	Arterial Sheath: Intact, sutured and capped;							
10:29:13	Venous Sheath: intact, sutured and capped;							
10:29:16	Venous Sheath: intact, sutured and capped;							
10:29:25	Site Status: No Bleeding/Hematoma - Rt groin							
10:29:31	INTV Complications: NONE - During Lab Visit							
10:29:37	Patient Out Of Room							
10:29:37	Patient transferred from Lab to Room 5007							
10:29:40	ABOVE DOCUMENTED BY:							
10:30:57	RA	17/ 17	(14)					(ROOM AIR REST)
10:31:27	RV	39/ 9,	16					(ROOM AIR REST)
10:31:33	RV	40/ 9,	15					(ROOM AIR REST)
10:32:12	PW	22/ 21	(18)					(ROOM AIR REST)
10:33:07	PA	18/ 19	(24)					(ROOM AIR REST)
10:34:48	Swan-Ganz Catheter: secured in place @: 71 cms (L1)							
10:36:36	PA	98%	(PV)					(ROOM AIR REST)
10:36:36	PA	87%	(PA)					(ROOM AIR REST)

LESION LOG

Name: CHERRY, PAMELA | **Date: 05-31-2011**

MRN: 32947889 | **Proc: Adult: Interventional**

09:57:02	L1 > (COR VESSEL) RCA
09:58:17	L1 > DEFIBRILLATED @ 300 JOULES W/BI-PHASIC DEFIBRILLATOR - Successful
09:58:34	L1 > Guidewire inserted
09:59:00	L1 > EQUIPMENT: Balloon: Selmed Apex Monomil 2.0 x 15mm
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10:23:22	L1 > Existing sheath exchanged for new sheath of different size per Procedure MD
10:26:25	L1 > ACT Results: 205 secs
10:27:31	L1 > Patient tolerated procedure well.
10:27:34	L1 > Intervention Procedure Complete.
10:27:37	L1 > INTV Contrast Type: Visipaque 320
10:27:41	L1 > INTV Contrast Total: 125 ml
10:27:43	L1 > ABOVE DOCUMENTED BY:
10:34:48	L1 > Swan-Ganz Catheter: sutured in place @: 71 cms